**Section 500.APPENDIX F Death Records**

**Section 500.ILLUSTRATION A Certificate of Fetal Death**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Type or Print in* |  | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | |
| **PERMANENT INK** |  | | | | | | | | | | | | | | | | |  | | | | | | | |
| *See Hospital and* | REGISTRATION DISTRICT NO | | REGISTERED NUMBER | | | | | | | STATE OF ILLINOIS | | | | | | | | | | | | | | | | | | | | | | | | STATE FILE  NUMBER | | | | | | | | | | | |
| *Funeral Directors* |
| *Handbooks for* | **CERTIFICATE OF FETAL DEATH** | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| *INSTRUCTIONS* |  | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
|  | FETUS-*NAME* | | | | FIRST | | | | | | | MIDDLE | | | | | | LAST | | | | | DATE OF DELIVERY (MONTH DAY YEAR) | | | | | | | | | | | | | | | | | HOUR | | | | | |
|  | 1. | | | | | | | | | | | | | | | | | | | | | | 2a. | | | | | | | | | | | | | | | | | 2b. | | | | M | |
| FETUS | SEX | COUTY OF DELIVERY | | | | | | CITY, TOWN, TWP OR ROAD DISTRICT NO | | | | | | | | | | | | | | | HOSPITAL –*NAME* (IF NOT HOSPITAL GIVE STREET AND NUMBER) | | | | | | | | | | | | | | | | | | | | | | |
|  | 3. | 4a. | | | | | | 4b. | | | | | | | | | | | | | | | 4c. | | | | | | | | | | | | | | | | | | | | | | |
|  | MOTHER-*MAIDEN NAME* | | | | | | FIRST | | | | | MIDDLE | | | | | LAST | | | DATE OF BIRTH (MONTH DAY YEAR) | | | | | | | | | | BIRTHPLACE  (STATE OR FOREIGN COUNTRY)  5c. | | | | | | | | | | | | | | | |
| MOTHER | 5a. | | | | | | | | | | | | | | | | | | | 5b. | | | | | | | | | |
|  | RESIDENCE - STREET AND NUMBER OR RFD | | | | | | | | | | | | CITY, TOWN, TWP OR ROAD DISTRICT NO | | | | | | | | | | | | | | INSIDE CITY  (YES NO) | | | COUNTY | | | | | | | | STATE | | | | ZIP CODE | | | |
|  | 6a. | | | | | | | | | | | | 6b. | | | | | | | | | | | | | | 6c. | | | 6d. | | | | | | | | 6e. | | | | 6f. | | | |
| FATHER | FATHER - *NAME* | | | | | | FIRST | | | | | MIDDLE | | | | | LAST | | | DATE OF BIRTH (MONTH DAY YEAR) | | | | | | | | | | BIRTHPALCE  (STATE OR FOREIGN COUNTRY) | | | | | | | | | | | | | | | |
|  | 7a. | | | | | | | | | | | | | | | | | | | 7b. | | | | | | | | | | 7c. | | | | | | | | | | | | | | | |
|  | INFORMANT'S SIGNATURE | | | | | | | | | | | | | | | | | | | | RELATIONSHIP | | | | | | | MAILING ADDRESS (STREET AND NO. OR R.F.D. CITY OR TOWN, STATE AND ZIP) | | | | | | | | | | | | | | | | | |
|  | 8a.► | | | | | | | | | | | | | | | | | | | | 8b. | | | | | | | 8c. | | | | | | | | | | | | | | | | | |
|  | 9. PART 1 FETAL DEATH WAS CAUSED BY | | | | | | | | | | | | | | (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c)) | | | | | | | | | | | | | | | | | | | | | | | | SPECIFY FETAL OR MATERNAL | | | | | | |
|  | FETAL OR MATERNAL  CONDITION DIRECTLY  CAUSING FETAL DEATH | | | | | |  | | IMMEDIATE CAUSE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
|  | { | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
|  | (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
|  |  | | DUE TO OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
|  | FETAL AND OR MATER-  NAL CONDITIONS, IF ANY,  GIVING RISE TO THE  IMMEDIATE CAUSE (a),  STATING THE UNDERLY-  ING CAUSE LAST | | | | | | { | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| CAUSE | (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| DUE TO OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
|  | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
|  | PART II OTHER SIGNIFICANT CONDITIONS OF FETUS OR MOTHER CONTRIBUTING TO FETAL DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART I | | | | | | | | | | | | | | | | | | | | | | | | FETUS DIED BEFORE LABOR, DURING LABOR OR DELIVERY UNKNOWN (SPECIFY) | | | | AUTOPSY  (YES NO) | | | | | | | | WERE AUTOPSY FINDINGS AVAILALE PRIOR TO COMPLETION OF CAUSE OF DEATH? (YES NO) | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | 10. | | | | 11a. | | | | | | | | 11b. | | | | | | | | |
|  | I CERTIFY THAT THIS FETUS WAS BORN DEAD AT THE PLACE AND TIME ON THE DATE STATED ABOVE | | | | | | | | | | | | | | | | | | DATE SIGNED (MONTH DAY YEAR) | | | | | | | | | | ATTENDANT – M.D., D.O., MIDWIFE, OTHER (SPECIFY) | | | | | | | | | | | | | | | | |
|  | *SIGNATURE* | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| CERTIFIER | 12a. ► | | | | | | | | | | | | | | | | | | 12b. | | | | | | | | | | 12c. | | | | | | | | | | | | | | | | |
| CERTIFIER'S COMPLETE MAILING ADDRESS (STREET AND NO OR R.F.D., CITY OR TOWN, STATE, ZIP) | | | | | | | | | | | | | | | | | | | | | | | | | | | | ILLINOIS LICENSE NUMBER | | | | | | | | | | | | | | | | |
|  | 12d. | | | | | | | | | | | | | | | | | | | | | | | | | | | | 13. | | | | | | | | | | | | | | | | |
|  | BURIAL, CREMATION, OR REMOVAL | | | | | | | | | | CEMETERY OR CREMATORY – *NAME* | | | | | | | | | | | | | LOCATION (CITY OR TOWN, STATE) | | | | | | | | | | | DATE (MONTH DAY YEAR) | | | | | | | | | | |
|  | (SPECIFY) | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | |
|  | 14a. | | | | | | | | | | 14b. | | | | | | | | | | | | | 14c. | | | | | | | | | | | 14d. | | | | | | | | | | |
|  | FUNERAL HOME | | | NAME | | | | | | | | | | STREET AND NUMBER OR R.F.D. | | | | | | | | | | | | CITY OR TOWN | | | | | | | | | | STATE | | | | | | | ZIP | | |
|  | 15a. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DISPOSITION | FUNERAL DIRECTOR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER | | | | | | | | | | | | | | | | | | | | | | | |
| 15b. | | | | | | | | | | | | | | | | | | | | | 15c. | | | | | | | | | | | | | | | | | | | | | | | |
|  | LOCAL REGISTRARS SIGNATURE | | | | | | | | | | | | | | | | | | | | | DATE FILED BY LOCAL REGISTAR (MONTH, DAY, YEAR) | | | | | | | | | | | | | | | | | | | | | | | |
|  | 16a. ► | | | | | | | | | | | | | | | | | | | | | 16b. | | | | | | | | | | | | | | | | | | | | | | | |

**Section 500.APPENDIX F Death Records**

**Section 500.ILLUSTRATION A Certificate of Fetal Death (Continued)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| VR-110-(11/89) | | | | | | | | |  | | INFORMATION FOR HEALTH AND STATISTICAL USE ONLY | | | | | | | | | | | | | (BASED ON 1989 U.S. STANDARD CERTIFICATE) | | | | | | | | | | | | | | | | |
|  | OF HISPANIC ORGIN? | | | | | | | | |  | | RACE-American Indian, | | | | | | | 19. EDUCATION | | | | | | | | | | | | 20. OCCUPATION AND BUSINESS/INDUSTRY | | | | | | | | | |
|  | (Specify below No or Yes-If Yes  specify Cuban, Mexican, Puerto Rican, etc.) | | | | | | | | |  | | Black, White, etc. | | | | | | | (Specify only highest grade completed) | | | | | | | | | | | | (Worked during last year) | | | | | | | | | |
|  |  | | | | | | | | |  | | (Specify below) | | | | | | | Elementary/Secondary (0-12) | | | | College (1-4 or 5+) | | | | | | | | Occupation | | | | | Business/Industry | | | | |
| 17. |  | | | | | | | | | 18. | |  | | | | | | |  | | | |  | | | | | | | |  | | | | |  | | | | |
|  |  | | No | |  | | | Yes | |  | |  | | | | | | |  | | | |  | | | | | | | |  | | | | |  | | | | |
| MOTHER | 17a. | Specify: | | | | | | | | | 18a. |  | | | | | | | | 19a. | | | |  | | | | | | | | 20a. | | | | | 20b. | | | | |
|  |  | | No | | |  | Yes | | |  | |  | | | | | | |  | | | |  | | | | | | | |  | | | | |  | | | | |
| FATHER | 17b. | Specify: | | | | | | | | | 18b. | | |  | | | | | | 19b. | | | |  | | | | | | | | 20c. | | | | | 20d. | | | | |
| 21. PREGNANCY HISTORY  (Complete each section)  MULTIPLE BIRTHS  Enter State File Number for Mate(s)  LIVE BIRTH(S)  FETAL DEATH(S) | | | | | | | | | | | | | | | | | | | | | MOTHER MARRIED? at delivery, conception or at | | | | | | | | | | | | DATE LAST NORMAL MENSES BEGAN | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | any time between (Yes or No) | | | | | | | | | | | | (Month, Day, Year) | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | 22. | | | | | | | | | | | | 23. | | | | | | | |
| LIVE BIRTHS | | | | | | | | | | OTHER TERMINATIONS  (Spontaneous and induced at  any time after conception) | | | | | | | | | | | MONTH OF PREGNANCY PRENATAL CARE BEGAN | | | | | | | | | | | | PRENATAL VISTS | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | First, Second, Third, Etc. (Specify) | | | | | | | | | | | | Total Number (if none so state) | | | | | | | |
|  | | | | | | | | | |  | | | | | | | | | | | 24. | | | | | | | | | | | | 25. | | | | | | | |
| NOW LIVING | | | | NOW DEAD | | | | | | (Do Not Include This Fetus) | | | | | | | | | | | WEIGHT OF FETUS | | | | | | | | | | | | CLINICAL ESTIMATE OF GESTATION | | | | | | | |
| Number | | | | Number | | | | | | Number | | | | | | | | | | | (Specify Units) | | | | | | | | | | | |  | | | | | | | |
| 21a.  None | | | | 21b.  None | | | | | | 21d.  None | | | | | | | | | | | 26. | | | | | | | | | | | | 27. | | Weeks | | | | | |
| DATE OF LAST LIVE BIRTH | | | | | | | | | | DATE OF LAST OTHER TERMINATION | | | | | | | | | | | PLURALITY | | | | | | | | | | | | IF NOT SINGLE BIRTH - Born | | | | | | | |
| (Month, Year) | | | | | | | | | | (Month, Year) | | | | | | | | | | | Single, Twin, Triplet, etc. (Specify) | | | | | | | | | | | | First, Second, Third, etc. (Specify) | | | | | | | |
| 21c. | | | | | | | | | | 21e. | | | | | | | | | | | 28a. | | | | | | | | | | | | 28b. | | | | | | | |
| DATE OF MOTHER'S BLOOD TEST FOR SYPHILIS (Month Day Year) | | | | | | | | | | | | | | | | | | | | | LABORATORY DOING THE SEROLOGY | | | | | | | | | | | | | | | | | | | |
|  | 29a. | | | | | | | | | | | | | | | | | | | | | 29b. | | | | | | | | | | | | | | | | | | | |
| 30a.  Printed by the Authority of the State of Illinois  Illinois Department of Public Health – Division of Vital Records | | MEDICAL RISK FACTORS FOR THIS PREGNANCY  (Check all that apply) | | | | | | | | | | | | | | | | 32. | | OBSTETRIC PROCEDURES  (Check all that apply) | | | | | | | | | | | | 34. | | CONGENITAL ANOMALIES OF  FETUS (Check all that apply) | | | | | | |
|  | |  | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | |  | |  | | | | | | |
| Anemia (Hct.<30/Hgb. <10) | | | | | | | | | | | | | | | | 01 |  | Amniocentesis | | | | | | | | | | | 01 |  | | Anencephalus | | | | | | | 01 |  |
| Cardiac disease | | | | | | | | | | | | | | 02 |  |  |  | Electronic fetal monitoring | | | | | | | 02 | |  | |  |  | | Spina bifida/Meningocele | | | | | 02 |  |  |  |
| Acute or chronic lung disease | | | | | | | | | | | | | | | | 03 |  | Induction of labor | | | | | | | | | | | 03 |  | | Hydrocephalus | | | | | | | 03 |  |
| Diabetes | | | | | | | | | | | | | | 04 |  |  |  | Stimulation of labor | | | | | | | 04 | |  | |  |  | | Microcephalus | | | | | 04 |  |  |  |
| Genital herpes | | | | | | | | | | | | | | | | 05 |  | Tocolysis | | | | | | | | | | | 05 |  | | Other central nervous system anomalies | | | | | | |  |  |
| Hydramnios/Oligohydramnios | | | | | | | | | | | | | | 06 |  |  |  | Ultrasound | | | | | | | 06 | |  | |  |  | | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | 05 |  |
| Hemoglobinopathy | | | | | | | | | | | | | | | | 07 |  | None | | | | | | | | | | | 00 |  | | Heart malformations | | | | | 06 |  |  |  |
| Hypertension, chronic | | | | | | | | | | | | | | 08 |  |  |  | Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | 07 | |  | |  |  | | Other circulatory/respiratory anomalies | | | | | | |  |  |
| Hypertension, pregnancy associated | | | | | | | | | | | | | | | | 09 |  |  | | | | | | | | | | | | | | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | 07 |  |
| Eclampsia | | | | | | | | | | | | | | 10 |  |  |  | 33. COMPLICATIONS OF LABOR | | | | | | | | | | | | | | Rectal atresia/stenosis | | | | | 08 |  |  |  |
| Incompetent cervix | | | | | | | | | | | | | | | | 11 |  | AND/OR DELIVERY (Check all that apply) | | | | | | | | | | |  |  | | Tracheo-esophageal fistula/ | | | | |  |  |  |  |
| Previous infant 4000 + grams | | | | | | | | | | | | | | 12 |  |  |  | Febrile (>100°F. or 38°C.) | | | | | | | | | | | 01 |  | | Esophageal atresia | | | | | | | 09 |  |
| Previous preterm or small-for-gestational-age infant | | | | | | | | | | | | | | | | 13 |  | Meconium, moderate, heavy | | | | | | | 02 |  | | |  |  | | Omphalocele/Gastroschisis | | | | | 10 |  |  |  |
| Renal disease | | | | | | | | | | | | | | 14 |  |  |  | Premature rupture of membrane (>12 hours) | | | | | | | |  | | | 03 |  | | Other gastrointestinal anomalies | | | | |  |  |  |  |
| Rh sensitization | | | | | | | | | | | | | | | | 15 |  | Abruptio placenta | | | | | | | 04 |  | | |  |  | | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | 11 |  |
| Uterine bleeding | | | | | | | | | | | | | | 16 |  |  |  | Placenta previa | | | | | | | | | | | 05 |  | | Malformed genitalia | | | | | 12 |  |  |  |
| None | | | | | | | | | | | | | | | | 00 |  | Other excessive bleeding | | | | | | | 06 |  | | |  |  | | Renal agenesis | | | | | | | 13 |  |
| Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | 17 |  |  |  | Seizures during labor | | | | | | | | | | | 07 |  | | Other urogenital anomalies | | | | |  |  |  |  |
|  | | | | | | | | | | | | | |  |  |  |  | Precipitous labor (<3hours) | | | | | | | 08 | |  |  | |  | | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | 14 |  |  |  |
| 30b. OTHER RISK FACTORS FOR THIS | | | | | | | | | | | | | |  |  |  |  | Prolonged labor (>20 hours) | | | | | | | | | | | 09 |  | | Cleft lip/palate | | | | | | | 15 |  |
| PREGNANCY (Complete all items) | | | | | | | | | | | | | |  |  |  |  | Dysfunctional labor | | | | | | | 10 | |  | |  |  | | Polydactyly/Syndactyly/Adactyly | | | | | 16 |  |  |  |
| Tobacco use during pregnancy | | | | | | | | | | | | | | Yes |  | No |  | Breech/Malpresentation | | | | | | | | | | | 11 |  | | Club foot | | | | | | | 17 |  |
| Average number of cigarettes per day \_\_\_ | | | | | | | | | | | | | |  |  |  |  | Cephalopelvic disproportion | | | | | | | 12 | |  | |  |  | | Diaphragmatic hernia | | | | | 18 |  |  |  |
| Alcohol use during pregnancy | | | | | | | | | | | | | | Yes |  | No |  | Cord prolapse | | | | | | | | | | | 13 |  | | Other musculoskeletal/integumental anomalies | | | | | | | |  |
| Average number drinks per week \_\_\_\_\_ | | | | | | | | | | | | | |  |  |  |  | Anesthetic complications | | | | | | | 14 | |  | |  |  | | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | 19 |  |
| Weight gain during pregnancy \_\_\_\_\_ lbs. | | | | | | | | | | | | | |  |  |  |  | Fetal Distress | | | | | | | | | | | 15 |  | | Down's syndrome | | | | | 20 |  |  |  |
|  | | | | | | | | | | | | | |  |  |  |  | None | | | | | | | 00 | |  | |  |  | | Other chromosomal anomalies | | | | |  |  |  |  |
| 31. METHOD OF DELIVERY (Check all that apply) | | | | | | | | | | | | | | | | | | Other (specify) | | | | | | | | | | | 16 |  | | (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | 21 |  |
|  | | | | | | | | | | | | | |  |  |  |  |  | | | | SOCIAL SECURITY NUMBER | | | | | | | | | | None | | | | | 00 |  |  |  |
| Vaginal | | | | | | | | | | | | | | | | 01 |  | MOTHER | | | |  | | | | | | |  |  | | Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | 22 |  |
| Vaginal birth after previous C-section | | | | | | | | | | | | | | 02 |  |  |  |  | | | | 35. | | | | |  | |  |  | |  | | | | | | | | |
| Primary C-section | | | | | | | | | | | | | | | | 03 |  |  | | | | SOCIAL SECURITY NUMBER | | | | | | | |  | |  | | | | |  |  |  |  |
| Repeat C-section | | | | | | | | | | | | | | 04 |  |  |  | FATHER | | | |  | | |  | |  | |  |  | |  | | | | |  |  |  |  |
| Forceps | | | | | | | | | | | | | | | | 05 |  |  | | | | 36. | | | | | | |  |  | |  | | | | | | | | |
| Vacuum | | | | | | | | | | | | | | 06 |  |  |  |  | | | | | | |  | |  | |  |  | |  | | | | | | | | |
| Hysterotomy/Hysterectomy | | | | | | | | | | | | | | | | 07 |  |  | | | | | | | | | | |  |  | |  | | | | |  |  |  |  |

(Source: Added at 15 Ill. Reg. 11706, effective August 1, 1991)